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IMPLEMENTATION OF MIDWIFERY CARE DOCUMENTATION FOLLOWING THE MINISTRY OF HEALTH OF REPUBLIC INDONESIA DECREE NO HK.01.07/MENKES/320/2020

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Abstract

Professional services and legal aspects of the midwifery profession are some of the duties of the midwife. However, in making midwifery care documentation, many midwives were not following the regulations, while this is one of the midwives' violations. This study aimed to determine how the implementation of midwifery care documentation following the Minister of Health Decree on professional standards midwife. The method used in this study was qualitative—data collection using human instruments and interview guidelines. The sample of this research was four private practice midwives as primary informants and the head of the Indonesian Midwives Association as a triangulation informant. The results showed that the documentation management carried out by the four informants was not following the Ministry of Health's decree because midwives still using narrative techniques, namely recording examination results without writing down progress notes. The obstacle encountered was that documenting midwifery care took a long time; there have been no complaints from the community regarding unsystematic documentation methods. There were no sanctions to the midwives who did not document their services as correct. This finding is inconsistent with the Minister of Health concerning licensing and implementation of midwifery practices article 46.

Keywords: Documentation of Midwifery Care, Midwife Professional Standard

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1. Introduction

Professional services and legal aspects are some of the duties of midwives as service providers. Health services that were not carried out following the authority were at risk of irregularities. The risk can be in the form of a violation of the patient's rights. Violation of patient rights will threaten patient safety, where there was no legal protection for patients. Therefore, to prevent such violations from occurring, midwives need to improve the quality of their services. [1]

Midwives are known for their friendly manners and service providers following a professional code of ethics. Midwives are needed to help improve the quality of health services according to community needs, protect consumers and midwives from non-standard practices. [2]

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The quality of midwifery services is oriented to applying the ethics code and midwifery care standards and satisfaction, which refers to applying all requirements for midwifery services. Of the two dimensions of the quality of midwifery services, the ultimate goal is patient satisfaction served by midwives. Midwifery services include detecting abnormal conditions in mothers and children, carrying out counseling and health education for individuals, families, and communities.[3] Quality documentation is done correctly and adequately because quality assurance is part of the development of health services. [4]

The implementation of the Minister of Health Regulation Number 28/2017 concerning License and Implementation of Midwifery Practices in Article 28 letter (e) explains that "In carrying out practice/work, midwives are obliged to record midwifery care and other services systematically."[5]

The Minister of Health of the Republic of Indonesia Decree Number HK.01.07/Menkes/320/2020 concerning Midwifery Professional Standards that Midwifery Care stated that management is the approach used by midwives in providing midwifery care starting from assessment, formulation of midwifery diagnosis, planning, implementation, evaluation and recording of midwifery care. The recording had to be written complete, accurate, concise, clear, and reliable. [6] Progress notes should be made in the form of Subjective, Objective, Assessment, and Plan (SOAP).. [7]

The problem that often occurs with midwives was not making documentation following regulations. This problem has been categorized as a violation of the midwife's professional standards. This study aimed to determine how midwifery care documentation and the obstacles midwives face in documenting their care following the Minister of Health decree.

2. Method

The method used in this research was qualitative to obtain data depth by collecting data as deep as possible from respondents to determine how midwifery documentation was applied. The research instrument used was interview guidelines with data collection techniques carried out by in-depth interviews with four private practice midwives as primary informants. The inclusion criteria were midwives who have a private practice that has been practice for ten years. The results of the interviews were recorded, and field notes were made. To avoid subjectivity, the researcher used a triangulation technique, in this case, the head of the Indonesian Midwives Association and the head of Tegal City Health Office as triangulation informants by looking for data from various interrelated sources and researchers conducting exploration to check the credibility of various sources. [8]

3. Results and Discussion

a. Midwives knowledge of the Ministry of Health Decree about midwifery professional standards

Most informants understood that there were rules that regulate the professional standards of midwives, some understood the contents in them, but some informants state that they did not know or forgot what the contents of the rules were.

"I know that there are regulations for the standard of midwifery professions; most of them, I also know the contents of the decree." (IU I)

"I know the decree of midwife profession, ma'am." (IU2)

"I know the rules, ma'am, but there are indeed some of the contents of the rules that I forgot."(IU3)

"Surely I know the rules, but I do not know all the contents." (IU4)

"I already know the professional standards of midwives because that is the guide of health workers, especially midwives, in carrying out their duties." (IT 1)

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According to Palifiana, midwives are the health workers who help reduce maternal and infant mortalities; midwives also provide services on an ongoing basis to ensure the quality of their services. Midwifery professional standards are needed as a reference in providing midwifery care.[9] Midwives who have good knowledge of documentation can assist midwives in avoiding mistakes that could lead to lawsuits.[10]

b. Implementation of Midwifery Care Documentation

Most informants did not compile complete documentation. The care provided was documented based on the type of care provided.

"As a midwife, I know about midwifery documentation which must be written systematically, but sometimes I wrote only certain points that were in an existing format such as assessment and physical examination results; for others, I did not write, and usually I will complete it before monitoring and evaluation from professional organizations."(IU I)

“"In making documentation of midwifery care, I only used notes in the form of a narrative covering the results of the patient's physical examination, but not the plan of care." (IU 2)

"The documentation of midwifery care that I made still used the existing format, but there was no progress record." (IU 3)

"Each documentation I made were different from antenatal care, intranatal care, postpartum care, to the newborn care; because the format was different, but there were no progress notes."”. (IU 4)

This finding was confirmed by triangulation informants where many midwives still did not complete the documentation of midwifery care. Most of them only followed the format provided, so the progress of the care that has been given to the patient was not recorded

“"The results of the monitoring and evaluation carried out by the Indonesian Midwives Association were found to see still midwives who did not systematically document. the midwife only filled in the format provided but did not write down the patient's progress data." (IT I)

The legal aspect of documentation is the making of records following the standards set by law. What needs to be considered in making documentation is documentation related to legal aspects, instructions for recording legally. [11] According to the Minister of Health decree, there is a standard of practice for midwives that explains midwifery care documentation, including data collection, diagnosis, planning, implementation, evaluation, and documentation. Documentation is carried out after each delivery of midwifery care.

Documentation discrepancies are still found indicating the midwife's non-compliance with the rules that have been set. Based on the results of the interview, no sanctions were given for the incomplete documentation.

"sanctions were never given; We were only reminded to make documentation systematically, usually submitted during monitoring and evaluation by the Indonesian Midwives Association." (IU.2)

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> *"There is no sanction." (IU.3)*

> *"There were no sanctions given by the Indonesian Midwifery Association, only to be reminded to complete the documentation according to the standards." (IU.4)*

Article 46 of the Minister of Health Regulation concerning the licensed and implementation of the practice of midwives explains that midwives who violate the provisions for the implementation of practice are subject to sanctions including verbal warnings, written warnings, revocation of midwife practice licenses, revocation of midwife practice licenses.

c. The Obstacles

The incompleteness of the documentation made was caused by time and being used to the old format.

> *"I usually did not write documentation systematically because sometimes there were already patients waiting in line, so I wrote as needed; the important thing was that there were notes." (IU.I)*

> *"It takes quite a long time to write documentation, so I did not do it." (IU.2)*

> *"I was used to making documentation the old way, and so far, there have been no problems regarding midwifery documentation in midwifery services." (IU.3)*

> *"If the documentation is carried out following theory, it is quite difficult if it is applied in a practice place, because sometimes when I want to write there is still a queue of patients, so I write according to the formatted without any developmental data." (IU 4)*

Midwifery care is a series of activities based on the decision-making process and actions taken by the midwife following the authority and scope of practice based on the knowledge and tips of midwifery. [12] Regulations that already exist in the decree of the minister of health regarding the professional standards of midwives as a reference for midwives in carrying out midwifery care. [13]

Legal sanctions that already exist in the Minister of Health decree regarding the license and practice of midwives have not been applied to midwives who violate one of them, such as unsystematic documentation. There were no reports from people who have been harmed due to unsystematic documentation so that administrative sanctions were not applied in these cases. [14]

Unsystematic documentation of midwifery care has never received complaints from harmed patients because patients also did not know their rights and obligations to prevent law enforcement from applying sanctions. [15]

The results of Sumiati's research, entitled an overview of the contents of documentation of midwifery services as evidence of midwife accountability in midwives' private practice, obtained documentation of antenatal care, intranatal care, postpartum care, neonates and infants, family planning, and emergency departments were unsystematic. [16]

4. Conclusion

The documentation carried out by the informants was not following the minister of health decree regarding the professional standards of midwives because midwives still used narrative techniques, namely by recording the results of the examination without writing down progress notes. The obstacle encountered is that

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documentation takes a long time, and as long as there are no complaints from the public regarding the unsystematic documentation of midwifery services, sanctions have never been applied. This is also not following the Minister of Health concerning the licensing and implementation of midwifery practice article 46.

5. References

[1] Dwienda, Octa Ristica, Juliarti, Widya. *Prinsip Etika dan Moralitas Dalam Pelayanan Kebidanan*. Yogyakarta : Deepublish ; 2014

[2] Rukiyah. Yulianti. Konsep Kebidanan. Jakarta ; 2011

[3] Heryani, Reni. *Etikolegal Dalam Praktik Kebidanan*, Jakarta : Trans Info Media ; 2016

[4] Fauziyah, Afroh. Buku Ajar Dokumentasi Kebidanan. Yogyakarta ; Nuha Medika ;2011

[5] Permenkes RI No 28 Tahun 2017 tentang izin dan penyelenggaraan praktik bidan

[6] Saminem. *Dokumentasi Asuhan Kebidanan Konsep dan Praktik*. Jakarta :EGC ; 2012

[7] Kepmenkes No HK.01.07/Menkes/320/2020 tentang standar profesi

[8] Setiawan, Ari dan Saryono. *Metodologi Penelitian Kebidanan DIII, DIV, S1 dan S2*. Yogyakarta : Nuha Medika ; 2011

[9] Dheska Arthyka Palifiana. Penerapan Pendokumentasian Asuhan kebidanan Pada Bidan Praktik mandiri, Vol. 4 No. 1 (2017) 39-49

[10]Sadi Is, Muhamad. *Etika Hukum Kesehatan*, Jakarta: Kencana ; 2015

[11]Widan, Hidayat. Dokumentasi Kebidanan. Jakarta; Salemba Medika ; 2011

[12]Undang Undang RI No 4 Tahun 2019 Tentang Kebidanan

[13] Dirdj0sisworo. Pengantar ilmu hukum. Jakarta ; Rajawali Pers 2012

[14]HR, Ridwan. *Etika dan Hukum Kesehatan*, Yogyakarta ; Nuha Medika ; 2014

[15] Muslihatun, mudillah. Dokumentasi kebidanan. Yogyakarta : Fitramaya ; 2011

[16]Sumiati. pendokumentasi pelayanan kebidanan sebagai bukti akuntabilitas bidan di praktik mandiri bidan, vol 3 No 1

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